Louisiana Medicaid
Infectious Disorders – Antibiotics – Lincosamides

The *Louisiana Uniform Prescription Drug Prior Authorization Form* should be utilized to request prior authorization for non-preferred lincosamides.

Additional Point-of-Sale edits may apply.

*These agents may have **Black Box Warnings** and/or may be subject to **Risk Evaluation and Mitigation Strategy (REMS)** under FDA safety regulations. Please refer to individual prescribing information for details.*

Approval Criteria

- There is no preferred alternative that is the exact same chemical entity, formulation, strength, etc.; **AND**
- Previous use of any preferred antibiotic (cephalosporin, fluoroquinolone, lincosamide, streptogramin, macrolide-ketolide, nitrofuran derivative, or tetracycline) - **ONE** of the following is required:
    - The recipient has had a *treatment failure* with at least one preferred antibiotic; **OR**
    - The recipient has had an *intolerable side effect* to at least one preferred antibiotic; **OR**
    - The recipient has *documented contraindication(s)* to the preferred antibiotics that are appropriate to use for the condition being treated; **OR**
    - There is *no preferred antibiotic that is appropriate* to use for the condition being treated; **OR**
    - **The prescriber states that the request is to *complete a course of treatment that was initiated while the recipient was in an inpatient facility*; AND**
- By submitting the authorization request, the prescriber attests to the following:
    - The prescribing information for the requested medication has been thoroughly reviewed, including any Black Box Warning, Risk Evaluation and Mitigation Strategy (REMS), contraindications, minimum age requirements, recommended dosing, and prior treatment requirements; **AND**
    - All laboratory testing and clinical monitoring recommended in the prescribing information have been completed as of the date of the request and will be repeated as recommended; **AND**
    - The recipient has no concomitant drug therapies or disease states that limit the use of the requested medication and will not be receiving the requested medication in combination with any other medication that is contraindicated or not recommended per FDA labeling.

Duration of authorization approval: 1 week to 6 months
An appropriate duration of authorization approval will be determined based upon patient-specific factors and the condition being treated.

References

Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; Retrieved from https://www.clinicalkey.com/pharmacology/

DiPiro JT, Talbert RL, Yee GC, Matzke GR, Wells BG, Posey L. eds. Pharmacotherapy: A Pathophysiologic Approach, 10e New York, NY: McGraw-Hill; Retrieved from https://accesspharmacy.mhmedical.com/book.aspx?bookid=1861

Revision / Date	**Implementation Date**
Single PDL Implementation	May 2019
Separated "Select Anti-Infectives" into individual therapeutic class documents / November 2019	January 2020
Formatting changes / April 2021	July 2021